WORCESTER STATE UNIVERSITY

Speech-Language-Hearing Center
486 Chandler Street
Worcester, Massachusetts 01602
508-929-8055 Fax: 508-929-8175

Date Received: _____
(Office Use Only)

SPEECH–LANGUAGE–HEARING CENTER

Audiology—Adult Case History Form (Confidential)

Please complete this form and send it and additional relevant reports (speech-language, hearing, neurology, psychology) from other agencies to the address above. This information will help us to plan your evaluation and/or treatment.

Personal Information

Date:_____

Name:_____ Legal name, if different:_____

Date of Birth:_____ Age:_____ Gender:_____ Pronouns:_____

Race/Ethnicity (Check all that apply): ☐ Prefer not to answer ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Latino/Hispanic ☐ Native Hawaiian/Other Pacific Islander ☐ White

Are you a Worcester State University **faculty / staff / student / none of these** ? Circle one.

Name of person giving information, if different from above:_____

Relationship to client:_____

Are you your own legal guardian? Yes ☐ No ☐ If no, please provide the name of your legal guardian here:

_____

Referred by:_____

Reason for referral:_____

Have you been evaluated or treated at this Center before? Yes ☐ No ☐

If yes, when and for what reason?_____

Contact Information

Address:_____
(# Street)

_____
City State Zip Code

Home Phone:_____ Cell Phone:_____ Business Phone:_____

History

Reason for visit (primary complaint): _____

_____

Have you ever had your hearing evaluated before? No ☐ Yes ☐
When and why? _____

Do you have concerns about your hearing? No ☐ Yes ☐

In which ear? Right ☐ Left ☐ Both ☐

When was the onset of your hearing loss?_____

Was the onset sudden? No ☐ Yes ☐ gradual? No ☐ Yes ☐

Does your hearing fluctuate from day to day? No ☐ Yes ☐

What was the cause of your hearing loss?_____

Please check any of the following that are true of your hearing now:

- ☐ I can hear, but I do not have a clear understanding of what I am hearing.
- ☐ I have difficulty hearing in one-on-one situations in a quiet environment.
- ☐ I have difficulty hearing in groups.
- ☐ I have difficulty hearing with background noise.
- ☐ I prefer to have the television turned louder than those around me.
- ☐ I have difficulty hearing on the telephone.

Do you presently use a hearing aid? No ☐ Yes ☐ If yes, for how long?_____

Have you ever been to an otolaryngologist (Ear, Nose, and Throat physician)?
No ☐ Yes ☐ : When and why? _____

Does anyone in your family have a hearing loss? No ☐ Yes ☐ : Who?_____

Have you ever been exposed to loud sounds (gunfire, heavy machinery, loud music, etc.)? No ☐ Yes ☐
Please explain. _____

Please indicate if you have / had any of the following:

- ☐ Noise in your ears or head
- ☐ Pain in your ears
- ☐ Fullness or stuffiness in your ears
- ☐ Facial numbness or tingling
- ☐ Drainage or discharge from ears

Do you ever feel dizzy, unsteady, or off-balance? No ☐ Yes ☐
If yes, is your dizziness accompanied by: Nausea No ☐ Yes ☐ Vomiting No ☐ Yes ☐
Noise in ears No ☐ Yes ☐

Do you have concerns about your speech, language, or swallowing skills? No ☐ Yes ☐
Please explain. _____

How would you rate your general health? Poor ☐ Fair ☐ Good ☐ Excellent ☐

Are you currently on any medication? No ☐ Yes ☐
If yes, please list: _____

Please indicate if you have ever had any of the following:

☐ Allergies	☐ Ear aches/infections	☐ High fever	☐ Seizures
☐ Anxiety	☐ Fainting	☐ Measles	☐ Shingles
☐ Arthritis	☐ Frequent colds	☐ Meningitis	☐ Sinus trouble
☐ Cancer	☐ Frequent laryngitis	☐ Mental Illness	☐ Tonsillitis
☐ Chicken Pox	☐ Frequent sore throat	☐ Mumps	☐ Tuberculosis
☐ Depression	☐ Frequent upper respiratory infections	☐ Otosclerosis	☐ Whooping cough
☐ Diabetes		☐ Pneumonia	☐ Other _____
☐ Dizziness	☐ Heart disease	☐ Scarlet fever	_____

Have you fallen in the last year? No ☐ Yes ☐
Have you fallen two or more times in the last year? No ☐ Yes ☐
Are you afraid to fall because of your balance? No ☐ Yes ☐
Please indicate if you have ever taken any of the following medications:

- ☐ Mycin Antibiotics (e.g. Streptomycin, Kanamycin, Neomycin, Gentamycin, Tobramycin, Amikacin, Erythromycin, Vancomycin)?
- ☐ Aspirin (or Aspirin containing products) at least 6-8 per day for extended periods of time?
- ☐ Non-steroidal anti-inflammatory drugs (Advil, Aleve, Indocin, Motrin, Naprosyn, Nuprin) at least 6-8 per day for extended periods of time?
- ☐ Quinine or quinine containing products (e.g., Malaria medicine, muscle cramps, excessive intake of tonic water)?
- ☐ Intravenous Diuretics?
- ☐ Chemotherapy?

If you checked any of the above medications, please elaborate: _____

Summary

Provide additional information that you believe might be helpful in the evaluation or remediation process. Attach additional pages if needed. _____

Signed:_____Date:_____

Reminder

Before returning this paperwork to Worcester State University Speech-Language-Hearing Center, have you:
Completed this case history in its entirety?
Read and signed the following release forms?
• Authorization for Observation and Audio/DVD Recording ☐
• Authorization to Obtain, Release and Discuss Client Information ☐
Contacted other agencies to have them forward reports to you or directly to the Worcester State University Speech-Language-Hearing Center?

For additional information, please contact the Center at 508-929-8055

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

_____ Diagnostic Evaluation _____ Therapy

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Authorization to Obtain, Release, and Discuss Client Information

Client's name _____
Print first name middle initial last name

Client's date of birth _____

Check all that you authorize:

☐ Get information from ☐ Send information to ☐ Discuss information with

_____
Print first and last name of person

_____
Print name of facility

_____
Print street address

_____
Print City, State, and Zip Code

_____ _____
Phone number Fax number

Please check
☐ I agree to have a graduate student clinician under the supervision of a clinical instructor, and / or the clinical instructor, obtain/release/discuss (see above) the following information from/to/with the above listed person/facility.

☐ I agree to have the audiologist obtain/release/discuss (see above) the following information from/to/with the above listed person/facility.

_____

_____

_____

Authorization: _____
Signature of client or guardian relationship to client

Date: _____

Clinical instructor reviewed: _____

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Authorization for Observation and Audio/Video Recording

I, _____, consent to the following that I have checked below
(person completing form)

for_____ (please check all that apply)
(Client's Name)

_____I consent and authorize the taking of photographs, audio and/or video recording as well as closed circuit televised monitoring of the client specified above (e.g., client and persons associated with the client), by the Worcester State University Speech-Language-Hearing Center (WSU-SLHC). I understand that the WSU-SLHC is an educational facility and therefore consent that the visual and audio displays as described above may be used for educational training or treatment purposes including (please initial all for which you give consent):

___ (1) Case managers, undergraduate and graduate students associated with the Worcester State University Communication Sciences & Disorders Department;
___ (2) Other professionals, such as speech-language pathologists, audiologists, educators, and administrators,
___ (3) Published or professional journals;*
___ (4) Professional or educational conferences.*

* Names of participants in the recording will not be disclosed

_____I consent and authorize the Worcester State University (WSU) Speech-Language-Hearing Center (SLHC) to allow qualified professional personnel and students connected with the WSU Department of Communication Sciences & Disorders and SLHC to observe all clinical activities (e.g., evaluation, therapy, counseling) provided to the client specified above (e.g., client or persons associated with the client) through one-way mirrors or by closed circuit television for professional purposes.

_____I consent and authorize the person (s) listed below to observe all clinical activities (e.g., evaluation, therapy, counseling) provided to the client specified above (e.g., client or persons associated with the client) through one-way mirrors.

_____ _____

_____ _____

_____ _____ _____
Client or Parent/Legal Guardian Date Case Manager

Revised/Fall 2016

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Consent for Access to Records

I consent and authorize the Worcester State University (WSU) Speech-Language-Hearing Center (SLHC) to allow faculty and clinical instructors connected with the WSU Department of Communication Sciences and Disorders to access and use my records/_____'s records (without the use of identifying
Client name
information) for research and/or academic purposes at WSU.

_____ _____
Signature Date

_____
Print name

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Client Consent for Research

Client Name: _____

The Speech-Language-Hearing Center serves as a training site for students in the Communication Sciences and Disorders Department at Worcester State University. As a research and teaching institution, we are asking your permission to use de-identified (your personal information has been removed) information for teaching and research purposes. An example of a teaching activity might be using de-identified test information to instruct students on how to administer a test and interpret scores. An example of a research activity might be, with permission from our Institutional Review Board, using de-identified information in presentations or in research papers.

I consent to allow members of the Communication Sciences and Disorders Department at Worcester State University to use de-identified information for:

- teaching purposes:
  - ☐ YES
  - ☐ NO
- research purposes:
  - ☐ YES
  - ☐ NO

I consent to be contacted regarding participation in a research study:

- ☐ YES
- ☐ NO

_____

Client or Parent/Legal Guardian

_____

Date